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CASES OF DOUBLE UTERUS AND VAGINA.[1]

BY JAMES R. CHADWICK, M. D.

CASE I. *Uterus and Vagina Double Throughout.* — On March 3, 1876, Mrs. B., of Irish parentage, forty years of age, married for twenty-six years, having had no children, but one miscarriage two years before, applied at my Dispensary for the relief of painful coition, dating from the time of marriage. Menstruation had appeared at the age of thirteen years, and had recurred regularly every fifteen days, with some pain and moderate flow. There was a steady backache.

Digital examination traced the dyspareunia to a tense, unruptured hymen, which barely admitted two fingers. Inspection of the genitals, with a view to relieving this condition by incision of the fibrous band, disclosed a second opening to the right of the other one, which allowed the passage of a single finger only. The two vaginal canals were separated throughout by a thick septum. Each vagina had an os at its extremity belonging to a common collum uteri. Owing to want of time and the promise of a second visit on the part of the patient no exploration of the uterine cavity was made, but I have reason to suppose that the double uterus was similar to that in the next case. The patient never returned.

This case is of interest as showing the cause of the fibrous unruptured hymen to which the symptoms were attributable.

CASE II. *Uterus and Vagina Double Throughout.* — Mrs. L. H., twenty-two years of age, one year married, applied at my Dispensary on May 2, 1877. She had had no children or miscarriages; had menstruated regularly from the age of fifteen years, with much flow, lasting four days, but very little pain. Last winter she had had a slight attack of pelvic inflammation, which had confined her to bed for a week. She sought treatment for a yellowish discharge from the vagina and for constipation.

On digital examination a thick vertical septum was found dividing the vagina in its median line; this took its rise from the vaginal wall anteriorly one half inch behind the urinary meatus, and posteriorly one

[1] Read before the Obstetrical Society of Boston.

inch above the fourchette ; it seemed as though the latter insertion had been partially torn off at the first attempt at coitus. The right vagina was more developed than the left, and seemed to have been generally if not always the one entered by the male organ. The hymen on the left side admitted two fingers, but bound them tightly. An os was felt at the top of each vagina, belonging to a common collum uteri. A sound passed into the uterus to the depth of two inches on the right side, and two and a half on the left ; the two sounds then lay side by side, but could not be made to touch each other ; while they were in position the left hand could be made to grasp the common fundus through the abdomen and thus determine positively that the malformation was of that variety known as *uterus septus duplex.* To the right of the uterus was a small ill-defined rounded body, distinct from the fundus, which was probably the remains of an old pelvic effusion.

A vaginal douche and a laxative relieved all the symptoms at the end of a week, since which time the patient has not been seen.

These two cases are illustrations of the simplest forms of duplicity in the female genital organs due to arrest of development during the embryonic period. The apposed walls of the two Müller's ducts, from which the genital tract is formed, fail to fuse, and disappear, but remain as a firm septum.

In the next two cases there was the same persistence of the septum, formed of the apposed walls, together with a failure of one side to establish an external opening.

Case III. *Double Uterus and Vagina ; Atresia of the Left Side.* — This case was seen in consultation with Dr. J. L. Sullivan, of Malden.[1]

Case IV. *Uterus Duplex Bicornis ; Double Vagina with Atresia of the Right Side.* — Mrs. W., of American parentage, applied at my Dispensary on August 13, 1877. She was twenty-one years of age, had had no children or miscarriages, having been married but three months. Menstruation began six months after her seventeenth birthday, and had since recurred without intermission every three and a half to four weeks ; the flow had generally lasted seven days, but was scant and attended by much pain. A white, offensive discharge from the vagina had persisted for most of the period since the establishment of menstruation ; there had likewise been constant pain in the back, genitals, and right hip. Marriage had produced no change in the symptoms, — a suggestive circumstance.

The patient was emaciated and bore the marks of protracted suffering on her face and in the deranged condition of the nervous system.

A digital examination revealed a rather narrow vagina, a uterus of normal size lying in the hollow of the sacrum, but freely movable. Along the right side of the vagina could just be detected a circum-

[1] See page 706 of the Journal.

scribed elastic resistance extending from the cervix to the right pubic ramus. Through the speculum no encroachment upon the vaginal canal was perceptible, but a minute opening in the vaginal wall was disclosed half an inch anterior to the os uteri in the median line; through this aperture pressure on the elastic body caused a most fœtid pus to exude.

The whitish discharge was thus tracked to a cavity lying alongside the vagina, the peculiarities of which led me to suspect an occluded second vagina. I accordingly sent her to the City Hospital for operation, with a guarded expression of opinion to that effect.

A few days later Dr. O. W. Doe, to whose ward she was assigned, inserted a much-curved wire probe through the opening, and cut down upon its point through the vaginal wall just behind the right pubic ramus. Less than an ounce of pus was evacuated, and the incision was carried back nearly to the collum uteri. The cavity could be traced along the collum for half an inch, but no further passage was then detected. Despite the failure to obtain corroboration of the diagnosis my conviction of its accuracy was not shaken.

A week later, in wiping out the cavity with cotton, I brought out a string of mucus which was attached to the uppermost extremity of the cavity. This, I argued, would have been free had it not come from a still undiscovered second cervical canal. A few days subsequently Dr. Doe was able to pass a sound two and a half inches into a uterine canal from the suppurating cavity. The only treatment had been disinfectant vaginal injections.

A month later the patient presented herself at my Dispensary, when I fully confirmed the existence of a second uterine cavity. The sound entered on the left side of the uterus directly upwards, while at the same time a sound in the right side passed directly to the right. Between the points of the two the left hand could depress the abdominal wall, thereby demonstrating that the cavities were contained in two separate horns of the uterus.

Suppuration had ceased, and the patient was rapidly regaining health, strength, and freedom from pain, which she had not had since girlhood.

The two last cases are chiefly of interest in the way of diagnosis. In each instance this was based, in my mind, upon the coincidence of the commencement of the symptoms with the establishment of the menstrual function; the long duration and the extremely offensive character of the discharge (in Dr. Sullivan's patient the odor was so bad as to prevent attendance at school, and any association with other girls); the absence of induration and fixation of the surrounding tissues, such as certainly would have been apparent had the suppuration been a result of peritonitic or cellulitic inflammation; and finally the fact that there is usually no natural cavity in this position — except the bladder,

which was proved healthy — that could become the seat of a suppurative inflammation.

The indications were unequivocal. The danger of septicæmia, which proves fatal after so many operations for the evacuation of retained menstrual blood, may have been lessened by the years of suppuration, but was probably averted, in great measure, by the thorough cleansing of the cavity with a disinfectant fluid immediately after the operation and for several weeks subsequently.

Case V. *Vaginal Septum.* — On October 29, 1877, Mrs. F., twenty-six years of age, married for five years, was brought to my dispensary for examination by Dr. W. P. Brechin, who had discovered a year and a half previously a vaginal septum. The patient had menstruated regularly and profusely since the age of eight years and two months, when rape was committed upon her by a man who was convicted for the offense, and is now serving a life sentence in the State's prison. She had had one male child, weighing six pounds, born seven years before. No miscarriages.

On examination a fold of mucous membrane was found to be hanging from the vaginal wall just behind the urinary meatus. This, Dr. Brechin stated, had, when last seen, an attachment to the posterior vaginal wall, thus forming a septum three quarters of an inch in width, dividing in two the vaginal entrance. The vaginal canal above the septum had been single. The patient asserted that the male organ sometimes entered one side and sometimes the other.

That this septum was congenital I cannot affirm, for it is quite possible that it should have resulted from the abnormal healing of the hymen and vaginal entrance, which were very extensively torn at the time of the rape.

It is certainly curious that the septum should not have given way during the birth of the child, and yet been broken down subsequently by coition.

The uterus was single and normal.

CASE OF DOUBLE VAGINA AND UTERUS, WITH CONGENITAL ATRESIA OF ONE OF THE VAGINAL DIVISIONS OR CHANNELS.

BY JOHN L. SULLIVAN, M. D., MALDEN.

Nellie D., resident of East Cambridge, seventeen years old last January, of Irish parentage, light complexion, good constitution, childhood healthy.

On July 4, 1874, in the fifteenth year of her age, the catamenia appeared for the first time, without pain; color and quantity normal.

She menstruated regularly until November of the same year, when the flow was scanty and attended with moderate pain. These symptoms were attributed to "taking cold." In January, 1875, she missed her period. In February menstruation was reëstablished, this time easy and natural. In March she experienced severe dragging pains, referred chiefly to the back, and voided per vaginam a good deal of fluid blood and several coagula. In April the catamenia were replaced by an offensive purulent discharge. This discharge returned at irregular intervals, and was sometimes tinged with blood. The family physician was now called; opiates were prescribed, a specialist was summoned in consultation, but no exact diagnosis could be established. In August, 1875, the patient suffered an aggravation of all the distressing symptoms; a much larger quantity than usual of fœtid pus escaped from the vagina, accompanied by agonizing pains resembling those of abortion. From this time until September, 1876, the discharge was continuous, but during the whole period (thirteen months) there was no admixture of blood. From the latter date until February, 1877, an occasional tinge of blood was noticed; from February to June none.

During this long period of menstrual irregularity and recurring uterine irritation it is worthy of note that there were no symptoms referable to the bladder or urethra, nor any, so far as could be learned, which pointed distinctly to inflammation of any of the pelvic organs or tissues. The general health suffered; the girl grew thin and pale and lost strength, and the appetite became capricious. The bowels were confined rather than loose, owing probably to the opiates to which she was obliged to have recourse. Aside from the pain and purulent discharge there were no other special symptoms noted.

Such were the particulars gathered on my first visit, June 5th. Temperature normal, pulse rather quick and feeble (pulse of irritation). Placing the patient on her back with the abdomen uncovered, I thought I observed an unusual fullness of the hypogastrium. On palpation there was a feeling of tension and resistance throughout that region, but no decided fluctuation. The percussion note was flat. The bladder, explored by the catheter, was found to be of normal size and not particularly sensitive, although displaced considerably to the left of the median line. On examining per vaginam, the patient being in the left lateral position, I detected a large, elastic swelling or tumor, situated in front of the vagina between it and the bladder (which it seemed to have pushed to one side), and extending upwards towards the umbilicus. My attention was next arrested by the discovery of a minute perforation of the anterior vaginal wall, situated in the median line, about an inch behind the meatus urinarius, and apparently communicating with the interior of the tumor. Into this aperture I succeeded in inserting a uterine probe, and passing it thence upwards and forwards until its

further advance was checked by the handle. The instrument could be moved freely in every direction, and had evidently entered a cavity of no small size. On withdrawal it was found smeared with fœtid pus. It now seemed clear that the case was one either of chronic abscess or of double vagina; if the latter, the anterior division or channel must have been congenitally closed with the exception of the minute opening described, or have been occluded subsequent to birth, and was now probably distended with retained menstrual secretions in a state of decomposition. I next sought for the portio vaginalis and fundus vaginæ, but the attempt failed on account of what seemed to be an elongation of the vagina, as if it had been stretched or drawn up beyond the reach of the finger, carrying with it the uterus. Being now satisfied that, whatever might be the nature of the swelling, a free incision and evacuation of its contents were required, I so informed the patient's friends, and in view of the possible dangers of the operation asked and obtained permission to secure Dr. Chadwick's assistance. Three days later, June 8th, the patient being etherized, a second and more thorough examination, digital and with the speculum, was made by both Dr. Chadwick and myself. Thanks to the anæsthetic, it was now possible to reach with the finger the vaginal cul-de-sac, and to distinguish at its summit a small orifice resembling an os uteri, into which a sound penetrated to the depth of half an inch. It was not, however, found possible to bring this orifice into view with the speculum, nor could any collum uteri be made out. The tumor was now incised by Dr. Chadwick, a director having been first thrust through the perforation already described as existing in the anterior vaginal septum; the latter was cautiously divided by a blunt-pointed bistoury carried upwards to within two inches of the supposed mouth of the womb. About a pint and a half of very offensive fluid of a dirty-green color escaped per vaginam. On exploring with the finger the cavity just laid open it proved to be a second vagina, largely dilated, and having an opening at its summit similar to that of its fellow, through which the sound passed into a second cavity nearly as deep as the first, and was thence pushed upwards until its extremity could be felt through the abdominal walls at a point a little to the right of the median line, two inches above the umbilicus. This cavity was believed to be that of the uterus, distended by the gradual accumulation of its own secretions and its abortive efforts to expel them, and so it proved. Very little hæmorrhage followed the incision, the compressed and condensed tissues divided being indisposed to bleed. After thoroughly syringing the parts with carbolized warm water the patient was left to recover. Her subsequent course was all that could be wished. The after-treatment consisted in cleanliness merely, disinfecting injections being repeated thrice daily. On the 17th of June, no unfavorable symptoms whatever having occurred, she

was again etherized, and the two vaginæ thrown completely into one by prolonging the original incision nearly to the os or rather ora uteri, for it was now plain that there were two. There was no hæmorrhage. A week later the patient was sitting up, and soon began to move about.

July 5th the menses appeared without pain, in every respect normal. August 5th, has been weighed, and found to have gained fourteen pounds; looks plump and well. Four weeks ago she was reëxamined by Dr. Chadwick and myself. We found one vagina, not much larger than normal, traversed at its summit by a vertical septum running obliquely from before backwards so as to form a double cul-de-sac with an os uteri debouching on each side, with hardly a trace of a cervix. A sound introduced into the right os, which had on a former occasion proved nearly impervious, penetrated to the depth of about two inches; a second, introduced into the left os, the other instrument being retained *in situ*, penetrated to the depth of two and one half inches. The contact of the sounds with each other was prevented by an intervening septum, dividing both the uterus and cervical canal into two separate, non-communicating cavities or cornua. The failure of the attempt before mentioned to explore with the probe the right uterine chamber, or that opening into the unclosed vaginal division or channel, may be explained by supposing that portion of the organ to have been compressed and its cavity temporarily obliterated by the distended left or opposite segment. From the suppression for successive months at a time of any sanguineous vaginal discharge, alternating with the transient appearance of blood mingled with the puriform secretion, amenorrhœa of the compressed cornu, or chamber, may be inferred, with partial reëstablishment of its functions at irregular intervals.

The above affords a good example of the first or simplest variety of so-called double uterus and vagina, uterus bicornis or bilocularis, in which the fissure is perfect, that is in which the septum descends to the external orifice, divides the latter, extends to the vagina, reaches as far as the pudenda, in the virginal state dividing the hymen, and forms a separate vagina for each half of the uterus. (Rokitansky.) The present case is interesting, first, from its being a rare form of congenital malformation; second, from the almost complete occlusion of one of the vaginal divisions and the train of unpleasant symptoms to which soon after the establishment of menstruation this condition gave rise. The interest is heightened by the difficulty experienced in forming an exact diagnosis during the early stage, before the development of any appreciable swelling or tumor that could direct attention to the real nature of the case. Later, when I saw the patient, the question of diagnosis had narrowed itself to the differentiation of double vagina from chronic abscess, the chief points of distinction being, first, absence of general symptoms denoting serious inflammatory action and of the facial expres-

sion characteristic of long-continued, copious suppuration; second, failure to discover local thickening or induration of the tissues, — anything, in short, like the walls of an abscess or pus-secreting cavity.

RECENT PROGRESS IN GENITO-URINARY SURGERY.[1]

BY T. B. CURTIS, M. D.

Spasmodic Stricture. — It has long been recognized that the urethra is surrounded by muscular fibres, both striped (compressor urethræ) and unstriped (layer of circular fibres), and that these muscular fibres, especially the first mentioned, by their contraction occasionally oppose the exit of urine and the entrance of instruments. Hence the name of spasmodic strictures applied to such contractions. With regard to their causes, Sir H. Thompson says that "a permanent stricture being present, however slight may be its extent, the canal is liable to be narrowed or even occluded at any time." According to a number of authorities (Sir H. Thompson, Dittel, Bumstead, Van Buren and Keyes, and others) these spasmodic strictures are to be distinguished from "organic or permanent strictures" by their short duration. "The grand distinguishing feature," says Sir H. Thompson, "which marks the phenomena we have thus ascribed to irregular muscular contraction, and by which they are contrasted with those of organic stricture, is their transitory character."

Dr. Otis,[2] however, distinctly takes issue with the authorities cited above with regard to the transitory character of the obstruction liable to be caused by urethral spasm. He believes that a spasmodic contraction possessing all the recognized characteristics of a deep organic stricture, including the persistency of the latter, can be kept up by reflex irritation of the urethra, originating in contraction of the meatus, or in slight (that is wide) organic stricture of the anterior portions of the urethra. In corroboration of this view he adduces six remarkable cases in which the following phenomena, among others, were observed: "(1.) A gradual diminution of the stream of urine. (2.) Persistent frequency of micturition. (3.) Persistent resistance to the introduction of large instruments in the hands of skilled surgeons. (4.) Distinct grasping of small instruments, and a gradual toleration of instruments of increasing size, in this so perfectly simulating the behavior of true organic stricture that the most skilled and learned surgeons have been deceived by these conditions. (5.) The persistence during a long period of years of all symptoms which are recognized by authorities as characteristic of organic stricture."

[1] Concluded from page 623.

[2] On Spasmodic Urethral Stricture. Archives of Dermatology, vol. i., No. 3.

In one of these cases the patient, a surgeon of New York city, aged sixty-two, had been under treatment for deep organic stricture for nearly twenty years. He had at times been able to pass only filiform bougies; false passages had resulted from attempts to pass the obstruction; chills and fever had been frequent; micturition was performed with difficulty as often as every half hour by day, and five or six times by night. Notwithstanding all these symptoms of organic stricture, from which the patient expected no relief save by a severe cutting operation, Dr. Otis, at his first examination, to the amazement of the patient, introduced with ease into the bladder a 28 F. conical steel sound, this calibre being that of the contraction, which was half an inch in length, commencing at the meatus. The normal calibre in this case, according to Dr. Otis's scale of proportion, was 34 F. The stricture was operated upon in the presence of Prof. Willard Parker, Dr. Gurdon Buck, Dr. Stimson, and Dr. Willard Parker, Jr. The anterior contraction was divided so as to admit a 34 F. bulbous sound, after which, without further cutting, a 30 F. steel sound was easily passed into the bladder. After the operation the patient, who had been urinating every half hour, held his water ten hours, and then passed it with a full, steady stream. A month later he was holding his water eight hours or more.

A seventh case, of a similar character to the others, was more recently published by Dr. Otis.[1] In this case a spasmodic stricture simulated organic stricture during a period of seventeen years. The spasm was dependent upon several wide anterior contractions, the narrowest of which measured 24 F. Relief had been attempted in vain by various surgeons, resulting several times in much hæmorrhage, but in no instance was the surgeon able to pass an instrument into the bladder. A complete cure followed the division of the strictures. At the conclusion of the report of this interesting case Dr. Otis says: "The foregoing case exemplifies in a striking manner the influence of anterior contraction in producing and perpetuating spasmodic stricture of a character identical in every respect with true organic stricture of the deep urethra, and which, as shown in the above case, resists every form of treatment which does not include complete restoration of the anterior portion of the canal to its normal dimensions."

The following statements embody important conclusions drawn by Dr. Otis from his experience: "It may," he says, "be safely claimed that no reliable examination of the deeper urethra can ever be made while a stricture, or even an erosion, is present in the anterior portion of the canal. Inferentially, then, no treatment of deep stricture, *per se*, should be attempted until the complete freedom from organic contraction of the anterior portions of the urethra is established."

Dr. Otis's views in relation to urethral spasm are corroborated by Dr.

[1] Archives of Clinical Surgery, December, 1876.

J. W. White,[1] who published recently an instructive paper on the diagnosis of urethral stricture by bulbous bougies. Dr. White's contribution has for its object to demonstrate, among other points, the possible occurrence of a spasmodic constriction almost undistinguishable from an organic stricture, and the occasional dependence of such spasms upon coarctations of large calibre situated in the anterior portion of the canal.

The authorities were not quite so clearly agreed as to the invariably transient character of urethral spasm as was stated by Dr. Otis. In a clinical lecture, published in 1867,[2] upon Spasm and Contracture of the Muscular Portion of the Urethra, the late Professor Dolbeau, of Paris, called attention to a spasmodic affection of the urethra simulating organic stricture. This affection was described as beginning insidiously and progressing irregularly; chronic, and in the highest degree refractory to treatment; producing a condition of hypochondriasis, and, finally, of marasmus, and generally terminating fatally. In the two cases reported by Dolbeau, there was, says the author, no organic or inflammatory stricture, but only an idiopathic spasmodic contraction of the urethra. Dolbeau alludes to the urethral spasm which, he says, is known to attend and result from organic stricture, even when of wide calibre, and which is liable to be exasperated by instrumental interference. This "symptomatic spasm" he distinguishes from the "idiopathic spasm," exemplified in his cases. With the new light cast by Dr. Otis's valuable researches upon the normal calibre of the urethra and upon the phenomena resulting from wide anterior strictures, the reported immunity from organic stricture of Dolbeau's patients may now bedoubted, as well also as the alleged incurability of the spasmodic affection observed by him.

Hypertrophy of the Prostate. — No very valuable addition has been made of late to our stock of knowledge concerning this disease. Several authorities on the subject have, however, recently contributed publications setting forth their opinions, practice, and results, the most important contributions being from Sir H. Thompson,[3] R. F. Weir,[4] Von Langenbeck,[5] Van Buren,[6] and Socin.[7] Dr. Weir, especially, in a clinical lecture, presents very clearly the important practical points relating to the recognition and management of prostatic hypertrophy. The subject is one of so much importance to the practitioner that a summary of the latest views is not unlikely to be useful.

With regard, in the first place, to diagnosis: The earliest symptom

[1] Philadelphia Medical Times, May 26, 1877, page 394.
[2] Clinique chirurgicale, Paris, 1867, page 265.
[3] The Lancet, January 6, 1877, page 1.
[4] American Clinical Lectures. Vol. ii., No. 8. New York. 1876.
[5] Berliner klinische Wochenschrift, January 22, 1877.
[6] New York Medical Journal, July, 1874. Genito-Urinary Diseases, by Van Buren and Keyes, New York, 1874.
[7] Prof. A. Socin. Die Krankheiten der Prostata. Stuttgart. 1875.

is one common to nearly all the diseases of the urinary organs, namely, irritability of the bladder, showing itself in excessive frequency of micturition. In cases of prostatic hypertrophy this vesical irritability, for some unknown reason, is much more troublesome at night than in the day-time. Met with in a patient who has passed the age of fifty, this symptom should at once awaken a suspicion of prostatic enlargement, and lead to a systematic exploration of the urinary organs. For a complete and satisfactory diagnosis it is necessary in every such case not only to determine positively the existence of obstructive prostatic hypertrophy, but also to ascertain the absence of other diseases of the urinary organs, especially vesical calculus and stricture. For this purpose a careful exploration with sound and catheter must at once be made, and cannot be deferred nor dispensed with.

"Our first thought," says Civiale,[1] "when we suspect an enlargement of the prostate, is to make a rectal examination with the finger. All the authorities recommend this proceeding. It has not, however, the value which we have been led by habit rather than by the results of observation to attach to it." Dr. Weir rightly attributes but little importance to the rectal exploration, for "hypertrophy may be present," he says, "without revealing itself *per rectum*."

The pathognomonic symptom of the disease is the presence of residual urine in the bladder after micturition. This all-important point is distinctly set forth by Dr. Weir. "Hence," he says, "the test of the introduction of the catheter immediately after urination is of prime importance."

The habitual presence of residual urine or "back water," and the absence of other diseases, especially of calculus, having been ascertained, the diagnosis of prostatic hypertrophy may be looked upon as established. It is then desirable to determine the quantity of urine habitually remaining behind after micturition, and the maximum amount tolerated by the bladder. These data, easily ascertainable by observation and measurement, are essential for prognosis and treatment.

"It is always a favorable sign for prognosis," say Van Buren and Keyes, "as far as the future comfort of the patient is concerned, to find a copious residuum upon the introduction of the catheter."[2] On the other hand, the most difficult cases to manage are those in which, with a small quantity of residual urine, not exceeding, perhaps, three or four ounces, the bladder is so irritable as to be intolerant of any considerable additional accumulation. The patient is then in the distressing predicament of being able neither to retain nor completely evacuate his urine, and is under the necessity of continually passing small quantities of urine with painful and laborious straining. If the chronic partial retention remain unrelieved, cystitis, caused by the continual presence

[1] Maladies des Organs Génito-Urinaires, Paris, 1858, vol. ii., p. 225.

[2] Genito-Urinary Diseases, New York, 1874, page 188.

of stagnating urine, sooner or later establishes itself in a more or less intense form, causing great additional suffering to the patient.

The treatment of prostatic hypertrophy is still purely palliative. The first object of the medical attendant should be to insure the sufficiently frequent evacuation of the bladder by means of the catheter. All the authorities are agreed upon the fact that the habitual use of the catheter is indispensable. Not only is this true of cases where no urine can be passed in the natural way, or where the amount of residual urine is large; the rule applies also to less marked cases, where stagnation exists only in a very slight degree. "It is your duty," says Dr. Weir, "when your examination is completed, to explain to your patient as clearly as you can the nature of the difficulty that he labors under, in order that he may be fully and thoroughly impressed with the fact that he must use the catheter for the balance of his life. No matter if he has only a tablespoonful of clear residual urine, if the diagnosis is positive, the treatment is so also." Sir Henry Thompson, in a recent lecture [1] on the question when the catheter should be used for habitual retention from hypertrophied prostate, speaks as follows: "I have heard it laid down, indeed, as an axiom, that so long as the urine is clear, no matter what the quantity retained, no instrument ought to be employed. A certain amount of *a priori* reasoning may be urged in behalf of such a rule, but it will not bear the test of large experience." This rule of never withdrawing the urine while it is clear, adds the author whom we are quoting, means nothing more nor less than waiting for the occurrence of cystitis before we use an instrument. Such a course is certainly not to be recommended.

With regard, however, to the most trifling degrees of obstruction to complete evacuation our authorities do not entirely agree. According to Van Buren and Keyes [2] it is most assuredly advisable to instruct a patient with enlarged prostate in the use of the catheter, even "if he has a very small amount of residuum, or none at all." Sir H. Thompson, on the other hand, says that "in an elderly man the presence of a drachm or two of residual urine suggests that at some future time he may require the catheter, but certainly it would not yet be necessary." [3] If, however, as much as two or three ounces are left behind after micturition, Sir H. Thompson recommends that the catheter be used at least once a day.[4]

The habitual use of the catheter by the patient being determined upon, the next point to be settled is the choice of an instrument. The majority of recent authors give their preference to more or less rigid instruments, such as the English gum catheter, or silver catheters of

[1] The Lancet, January 6, 1877, page 1.
[2] Loco citato, page 196.
[3] Clinical Lectures, fourth edition, 1876, page 204.
[4] Diseases of the Prostate, fourth edition, 1873, page 177.

various curves. Dr. Weir, with excellent judgment, recommends the flexible rubber catheter as the most suitable of all. Socin also is of opinion that this instrument should always be tried first, preferably to all others.[1] Another very valuable instrument, second only to the rubber catheter, often, indeed, to be preferred to it, is Mercier's gum catheter with a short elbow near the end. This instrument, known in France as the "old man's catheter," is generally very easy to introduce without pain or injury. Both of these flexible instruments are efficient and safe even in unskilled hands; it is impossible with them to inflict a false passage, and one or the other will often penetrate easily into the bladder in cases where the use of a rigid instrument is fraught with difficulty and danger. Metallic catheters, on the other hand, especially the long silver prostatic catheter, which practitioners unskilled in surgical manipulations too often insist on using, not unfrequently prove murderous weapons.

The habitual use of the catheter having been enjoined upon the patient, and a suitable instrument having been selected and found to answer the requirements, two important points claim attention from the surgeon, requiring his best care, patience, and judgment.

In the first place, tolerance of catheterization must be established. In some cases no difficulty is experienced. The stagnant urine, which was the source of all the annoyance, pain, and danger incurred by the patient, is drawn off at regular intervals, with entire relief. These fortunate cases, as shown by Van Buren,[2] are those in which there is a large amount of residual urine, together with a condition of vesical atony.

Often, however, the first effect of catheterization is unfavorable. The immediate relief occasioned by the complete evacuation of the bladder is soon followed by soreness and pain throughout the urethra, together with increased vesical irritability and a decided exasperation of the symptoms originally complained of by the patient. This result is mainly due to the production of cystitis in cases hitherto free from that complication, and to the exasperation of previously existing inflammation in cases where chronic retention had already occasioned cystitis. This complication is one that is almost certain to occur at some time in every case of obstructive prostatic disease. Stagnation of urine, if unrelieved, sooner or later occasions it. The use of instruments causes it, or occasionally makes it worse if already existing. The management of the case is then often difficult. The object of treatment is still the complete evacuation of the bladder, with the removal of the stagnating, decomposing, and, consequently, irritating urine, by means of the catheter, together with the use of injections, if necessary. At the same

[1] Die Krankheiten der Prostata, Stuttgart, 1875, page 76.

[2] Genito-Urinary Diseases, page 196. New York Medical Journal, July, 1874, page 1.

time, tolerance of the frequent passage of instruments is gradually to be established.

When the irritation is very decided, great caution is required in the prosecution of the all-important local treatment. In relation to these cases Dr. Weir gives very sound advice. Intervals of a week or more must be allowed to elapse between the successive introductions of the catheter. After a while the intervals can be decreased until the instrument can be used without irritation once, twice, or thrice daily.

When acute cystitis supervenes, with frequent, burning micturition, torturing vesical tenesmus, cloudy, muddy, or bloody urine, and other symptoms, then, according to Dr. Weir, "the use of the instrument must be stopped until the attack has fully passed over and has either resumed or taken on the chronic form." At the same time the usual medical treatment of acute cystitis, summed up by Van Buren and Keyes under the threefold headings of "attitude, alkali, and anodyne," must be applied.

Finally, to deal with that most refractory class of cases in which great irritability of the bladder exists with but little residual urine, here also, according to Dr. Weir, "perseverance with the catheter is to be encouraged. Comfort may perhaps be obtained by injections of hot water into the bladder, as hot as can be well borne, and with as much pressure, gradually increased, as can be tolerated. . . . . But the confession must be made that failure is more frequent than success in this variety of prostatic troubles. . . . . Where failure has occurred in overcoming the intolerable cystitis by the various expedients that I have brought to your attention," adds Dr. Weir, "and especially if inherent difficulties to the easy or daily introduction of an instrument are present, naught remains but the procedure put into use some ten years since by Van Buren, and more recently by Thompson, of making a permanent supra-pubic opening into the bladder, and thus allowing the prostatic urethra to fall into disuse."

PROCEEDINGS OF THE BOSTON SOCIETY FOR MEDICAL IMPROVEMENT.

F. B. GREENOUGH, M. D., SECRETARY.

October 22, 1877. *Fracture of the Spine.* — Dr. Jackson showed a portion of the spine, in which there was a fracture of one of the dorsal vertebræ. The intervertebral substance was torn through, except along the anterior edge, where it is more fibrous and resistant. There the upper edge of the body of the vertebra was broken off, and all around the anterior half; and, in close connection with the vertebra above, it was carried forwards and downwards. The patient lived for more than a year and a half, and yet the spinal canal was so obstructed by the displacement that a probe could scarcely be passed through.

Dr. Jackson showed two specimens, from the cabinet, that illustrated the same form of fracture, and that, he thought, had not been sufficiently noticed by surgical pathologists. When the patient lives long enough for the upper edge to be reunited to the body of the bone it often looks not very unlike a transverse fracture of this last, and is probably sometimes mistaken for it.

At a subsequent meeting Dr. Jackson showed another and a similar specimen. The fracture was of the first lumbar vertebra, and the displacement was such that its upper edge was carried by the last dorsal so far downwards as to rest upon the upper edge of the second lumbar. The great displacement caused a very marked projection at the seat of injury, and the symptoms were such as might be expected, the pain being very severe. The patient was a laborer, twenty-two years of age, and lived six months after the accident, which was caused by a bank of earth falling upon him.

November 12, 1877. *Unilateral Functional Spasm.* — Dr. J. J. Putnam showed a case of unilateral functional spasm presenting some of the features of the so-called "athetosis," at the same time that it belongs distinctly in the class with the so-called "post-hemiplegic choreas."

The patient was a girl eight years old, and the symptoms had developed gradually after an attack of scarlet fever when she was two years of age.

The preceding paralytic symptoms were so slight that they had been laid by the mother to weakness consequent on the fever, until a neighbor remarked that the child dragged the left foot somewhat in walking, and the time could not be distinctly stated at which the spasmodic symptoms first appeared. There had never been convulsions except at the time of the fever.

The movements as a rule occur only in connection with voluntary efforts on the part of the patient, but then they are slow and of shifting character, throwing the fingers into the positions commonly described as belonging to athetosis, and, when strong, extending the arm forcibly at the elbow and rotating the fore-arm outwards. At times the muscles of the left side of the face are included in the spasm, together with the frontalis on both sides, but most on the left, as well as the muscles of the left side of the trunk and the left leg. During walking the toes of the left foot are moved in a similar manner to the fingers.

The patient has been under treatment by electricity at the Massachusetts General Hospital for several months, and has seemed to gain somewhat, though it is difficult to say for what precise reason.

Puerperal Fever. — Dr. Wheeler reported a case of puerperal fever terminating fatally, which was, he thought, in some respects uncommon. He had seen the patient at two different times, having had charge of her for ten days from the sixth day after delivery, and being called in again twenty-four hours before her death, which took place about nine weeks after her confinement. The patient was a German, thirty-two years old, and this was her second confinement. During labor she had been attended by an irregular practitioner. The child was still-born, and on the third or fourth day she had chills. Dr. Wheeler was called in on the sixth day, and found no tenderness of the abdomen, but a very profuse and offensive lochial discharge. On the following

day the temperature was 103°, and the discharge gradually ceased, and for a time it looked as though she would pull through. The chills, however, returned, and occurred daily, sometimes even twice a day, the patient became elirious, and the prognosis was a very unfavorable one. After ten days' attendance Dr. Wheeler retired from the case, as the family desired to place her in the hands of a German physician, who, however, also ceased his attendance before her death. Twenty-four hours before death (which was in the ninth week) Dr. Wheeler was again called in. He found the patient much emaciated, the abdomen enlarged, and having chills daily.

At the autopsy the liver was found to extend to the left hypochondrium, measuring fifteen inches in one diameter by twelve in the other, and of a dark mahogany color. The spleen was also much enlarged, being about three times its normal size. No adhesions, no pus, or evidence of peritonitis were found. The uterus was normal; in short, with the exception of the enlargement of the liver and spleen, nothing abnormal was found. In answer to a question, Dr. Wheeler stated that the intestines were examined, and no enlargement or ulceration of Peyer's patches discovered. He regarded the persistency of the rigors as interesting and unusual, they being so marked that had there been any possibility of exposure to malarial influences he should have considered the case as one of intermittent fever.

Dr. Jackson said that in cases very similar to Dr. Wheeler's he had sometimes found, as the sole lesion, a low degree of inflammation of the mucous surface of the uterus, and apparently verging to gangrene; a dusky redness, a smearing of the surface with an offensive puriform fluid, and a scattering of small, thin, superficial fragments of lymph. Enlargement of the spleen he thought that he had seen, but not of the liver.

Aneurism of the Aorta. — Dr. George C. Shattuck reported the case and showed the specimen. The patient, aged thirty-eight, had been healthy until 1862. At that time he was serving as an officer in the artillery of the United States army, and he was troubled with a pain which he describes as starting from the left lower ribs and extending down along the course of the ureter to the testicle. He could not, however, connect this pain with any especial exertion or exposure. The pain was general, dull in character, but he had occasional paroxysms of acute suffering; he lost both flesh and strength, but was able to attend to his duties up to the time of his discharge, which took place in 1865. For eight months he did no work, and then, the pain being less, drove a stage in New Hampshire for two and one half years, during this time being much exposed to the weather. Then for four years he drove a hack in Boston, and during this period he was never free from pain for more than two or three days at a time. In 1873 he was suddenly attacked with nausea and vomiting and a violent palpitation in the front part of the chest and abdomen, where marked pulsation could be seen and felt. In 1874 a curvature of the spine in the dorsal region was first noticed, and about a year ago a boring pain, extending down his left thigh to his knee, came on. Last spring he took to his bed, and about that time he had a very violent attack of dyspnœa and vomiting, which lasted two hours. Since January, 1877, he has not been able to lie on his left side. He was admitted to the Massachusetts General Hospital September 26th.

He was at that time pale, emaciated, and weak. Pulsations visible over front and back. Complained of severe pain along the course of left ureter and into left testicle. Pain paroxysmal; also severe boring pain in left thigh. Pain not especially increased by motion or sitting up. Lay only on right side or back. He was too weak for thorough examination. Pulse was weak, and scarcely perceptible in femorals. Pulsation to be seen nearly all over lower part of back and abdomen, especially the left side in the back and the right side in front. Pulsation synchronous with that of heart. Heart sound heard wherever pulsation seen.

Dullness from fifth rib in front to three inches below ribs on right side, and in lumbar region on both sides behind. Double murmur heard at apex of heart, which was about normal in situation. Systolic souffle heard just below ensiform cartilage, and also over carotids. Subcrepitant râles in right chest. General sense of resistance in right abdomen, but no distinct tumor felt.

Urine showed cystitis and some interstitial nephritis.

He required large amounts of morphia for pain. He seemed to get weaker and to have more pain at first. Later he got slowly better, the appetite improved, and he had less pain.

At time of death he was quite strong, sat up every day, and ate fairly. Had much less pain, and paroxysms very seldom. The pulsations in abdomen, etc., had by this time become quite imperceptible. He died suddenly. He had just changed his shirt and got back to bed, when suddenly he became very pale and pulseless, and died in five minutes.

Dr. Fitz makes the following report of the autopsy: —

Death was the result of hæmorrhage into the abdomen from a rupture of an aneurism of the abdominal aorta; three quarts of liquid and clotted blood were found in the abdominal cavity. The aorta presents a series of aneurisms, the largest, the wall of which is ruptured, being of the size of an infant's head. It arises from the anterior wall of the aorta, beginning just above the diaphragm, and extending as low as the renal arteries. The bodies of the vertebræ are eroded, the spinal dura mater being exposed to a limited extent. On each side of the aneurism is a globular tumor, nearly as large as the former and intimately connected with it. These tumors lie behind the kidneys and psoas muscle, and are filled with laminated and decolorized clots. The cœliac axis and superior mesenteric artery arise from the front of the aneurism and are dilated, but otherwise unaltered. The inner surface of the lateral aneurismal pouches are incrusted with earthy matter, and that of the true aneurism presents numerous calcareous plates.

Valvular Thrombus, with Ulceration of the Endocardium. — Dr. Shattuck reported the case and showed the heart.

The patient, a mason, seventy years old, had a chancre twenty-five years ago, but was always very healthy. He drank a good deal, and used much tobacco.

Two months ago taken with sharp pain about umbilicus, lasting for some time; this he still had when he entered the hospital. Pain is very severe and sharp. Has been jaundiced since he first had pain. Dejections were clay color; now natural in appearance.

For some time before attack, and for about a week after, passed very little

urine. At first for five days, he says, passed no urine and had no dejection. Has not vomited. Complains of pruritus. Pulse weak, rapid, and very irregular. Somewhat jaundiced now. Micturition frequent. Bowels constipated. Urine contains no bile, a trace of albumen, much sediment, and granular casts with renal epithelium and few pus cells.

Patient given cathartics and bowels kept loose. At first slept a good deal. Complains little of pain.

November 1st. Patient noisy most of time for no apparent reason. Complains to day of severe pain in right shoulder, which is swollen and tender; cannot move upper arm. This thought to be rheumatism. Passes forty-eight ounces of urine.

November 6th. Very noisy, getting out of bed. Still pain in shoulder, but little pain in abdomen.

November 8th. Lies in a stupid and sleepy condition. Does not seem able to move himself much. Very weak. Pulse very weak and rapid. Temperature 101.4° to-night. Eats but little. Bowels loose; passes fæces in bed. Laxatives omitted.

November 9th. Temperature 98° in morning, 102° at night. Quiet. Complains of no pain. Cannot feed himself.

November 10th. Answers questions slowly. Quiet. Temperature 100° in morning, 101.8° at night. There is but little urine, but what he does pass he passes in bed. Pulse 130, very irregular.

November 11th. Temperature 101° in morning. Pulse 120, quite regular. Noisy at six A. M.; perfectly quiet the rest of the time. Respiration very quick, labored, and intermittent. Profuse sweat. Quite unconscious. Does not speak. No dejection for two days. Urine passed in bed. Complained of pain in chest. Died at nine P. M. Temperature to-night 105.2°.

The following report of the post mortem is by Dr. Fitz: —

The heart is relatively normal in size, its pericardium injected and velvety. About an ounce of opaque, flocculent fluid was removed from the sac. The aortic valves were insufficient in consequence of a perforation of the crescent below the origin of the left coronary artery. From the lower surface of this valve a thrombus as large as a filbert projected into the ventricular cavity. The opposed surface of the wall of the ventricle of a diffuse red color, without lustre, rough. The myocardium opaque and yellow in the immediate vicinity of the red patch.

Perforation of the Intestine in Typhoid Fever. — Dr. Lyman reported the case and showed the specimen. The patient, a woman, was admitted to the City Hospital September 17th. She was very dull, and beyond the fact that she had been sick two weeks could give no history of her case. On entrance her skin was warm, and there was no tympany and little tenderness of the abdomen. She became delirious, with feeble pulse, gradually ascending from 120 to 138, and on October 1st, when Dr. Lyman took charge of the ward, he found her with a pulse of 134 and temperature 104°. From 18th to 29th of September had had no operation. On October 4th she collapsed suddenly at eleven A. M., and died at 6.30 P. M. The specimen exhibited showed a perforation of the intestine.

Dr. Lyman also reported the following case, in which he said he had expected to find a perforation. The patient, a young man aged seventeen, entered the hospital October 1st, with a history of three weeks previously having had a pain across the chest, which soon disappeared and was replaced by a cough. The expectoration was abundant, thick, and white. Three days before admission he had diarrhœa, with much pain, the movements being almost continuous through the day, but not bloody nor accompanied with tenesmus. Had not had epistaxis nor headache. The tongue was parched and glazed, and there was very marked tenderness in right iliac fossa. Pulse 120, temperature 103.4°. He constantly complained of pain. At the visit on the 5th inst. he was found collapsed, with his knees drawn up, and in much pain. He died before ten A. M. In this case no perforation could be discovered, but there was general peritonitis.

Dr. Jackson said that the perforation of the intestine which occurs in typhoid fever is sometimes very small. There was a specimen in the museum in which the perforation was a mere pin hole. He had preserved this for the purpose of showing the necessity of a thorough examination of the intestine in cases where the symptoms have pointed to the probability of perforation.

Myeloid Tumor of the Fibula. — Dr. Beach showed a foot which had been amputated by Dr. Bigelow for this disease.

The patient, a young man of twenty-six years, had two years ago first noticed a swelling just above the external malleolus, which gradually increased to its present size (that of a fist). He had never had much pain, and was able to walk. A week ago Dr. Bigelow, by means of a canula, removed some fragments of tissue from the interior of the tumor, which, after a microscopic examination, Dr. Fitz pronounced to be giant-cell sarcoma. The foot was amputated at about the junction of the lower with the middle third of the leg, and the specimen exhibited. A section through the tumor showed myeloid structure, which had evidently started from the medullary canal of the fibula. This bone was at its lower end distended, absorbed irregularly, and fractured. There had been little or no pain although the peroneal branch of the cutaneous nerve was seen lying over the tumor in such a way that it must have been both stretched and compressed. The fact of the patient's having been able to walk with a fracture of the fibula was also interesting.

Fatty Hernia. — Dr. Fifield reported the case of a man who was brought to the City Hospital much injured by being forcibly ejected from a house during a fight. In the struggle he had been pounded, jumped upon, etc. A tumor was noticed near to and above the umbilicus. It had been considered a ventral rupture strangulated, the man being in a partially collapsed state. Dr. Fifield, however, on seeing it, at once recognized a "fatty hernia," and cutting down on the tumor showed that the diagnosis was correct. On trimming the mass with scissors a smart hæmorrhage showed that it contained a small artery in its centre. This was an additional evidence of the diagnosis, as these fatty herniæ advance forwards through a crack or fissure in the tendi nous expansion of the abdominal parietes, which crack or fissure originally gave passage to a blood-vessel. Hence a necessity exists for ligaturing *en masse* the base of such herniæ before cutting it off. A post-mortem examina-

tion showed that death had resulted from a fracture of the liver. At the site of the hernia the peritonæum had been pulled along by the fatty mass so as to present a small depression or sac. These herniæ are of the class known as "hernies par éraillement," and in this class occupy the subdivision "hernies graisseuses," either of the linea alba or simply as hernies graisseuses in general. Cruveilhier gives a very excellent description of them in the first volume of his Anatomie Pathologique Générale, page 634. M. Bernutz, in his inaugural dissertation, published at Paris in 1848, has also well described them. It was by the chance of finding this thesis in the library of the Medical School in Paris that my attention was first called to these hernias. Cruveilhier describes them as follows: "Their mechanism is very simple: a little lipoma insinuates itself with the vessels which traverse the aponeurotic walls of the abdomen dilates these vascular openings like a wedge, and finishes by escaping outwards. It is impossible to distinguish *a priori* a fatty hernia from an omental, and many fatty hernias have been operated on under the belief that they were omental. They are more often above than below the umbilicus, sometimes at the median line, sometimes at one side." M. Bernutz, as cited by Cruveilhier, has given a very different interpretation of fatty herniæ with issue of the peritonæum. He believes that the peritonæum encountered at the centre of these fatty herniæ is the remnant of an old hernial sac, that the fat is consecutively formed around it, and that it is one of the principal elements of the radical cure of herniæ, and even pretends that the celebrated case of Ambrose Paré was nothing more nor less than one of those adipose masses exterior to the peritonæum, although it was regarded by this illustrious surgeon and by those about him as "formed by the omentum folded (*ramassé*) upon itself and adherent."

Still another form of these herniæ must be alluded to. Although strictly belonging to the class of "hernies par éraillement," they take an easier path by nature of their original situation, and instead of bursting through a crack descend along the inclined plane of the inguinal or femoral canal. Carsten Holthouse is the only English authority I find who refers to them. In France they are known under the name of the "hernie graisseuse de Pelletan;" sometimes also called the fatty tumor of the spermatic cord. Holthouse gives a case of one of these fatty herniæ operated on by Maunder at the London Hospital under the idea that it was a true hernia. Mr. Annandale, of Edinburgh, committed the same mistake. Holthouse gives the differential diagnosis as follows: (1.) They are of slow growth, and come on without obvious cause. (2.) Their growth and increase of bulk are progressive, never larger at one time and smaller at another. (3.) When pinched up between the fingers they have a lobulated and dimpled appearance. (4.) When lifted off the parts below there is no impulse on coughing. (5.) They are never reducible.

THE SEA-SHORE HOME.

Some years ago a number of benevolent persons, justly horrified at the infant mortality among the poorer classes during summer, bethought themselves of a plan to save at least a few of the victims by removing them to a house near the sea where care, comfort, and pure air would undo the work of disease, filth, and heat. For three summers the home has been in operation, but at different places, and now the directors appeal to the public for funds to enable them to procure a permanent situation. The record of work accomplished is very gratifying. In the first year the physicians of the Dispensary, who sent most of the cases, were requested not to send the children who were already in a critical condition. It was thought that many deaths would injure the reputation and thus impair the usefulness of the institution, and that it was better to strive to ward off threatened dangerous disease than to try to cure it when present. The results, however, were so good that after one season a radical change of policy was made, and physicians were directed to send the very sickest children. The report of Dr. E. T. Williams, the attending physician, shows that last summer one hundred and thirty-two persons were admitted, seventy-nine being children and fifty-three mothers. All the children were, of course, under treatment, and twenty-nine of the mothers. Of the patients only seven died, all of whom were under two years of age, and five of whom were under one. When we remember the nature of the cases taken this must be considered a remarkable result. This charity is one which is not likely to be abused; the Dispensary physician who sends the patient sees the home and surroundings; and, if we are not mistaken, it is almost invariably the physician who urges the removal of the child, not the parents who ask for it. A large sum is not needed, and it is believed that if the institution had a situation of its own it could be conducted both more efficiently and economically. We are sure that all who have seen much of this charity will join us in commending it.

MEDICAL NOTES.

— Dr. B. E. Cotting entertained the staff of the Medical Journal, with other friends, at his residence on December 13th. Dr. Richardson furnished the intellectual entertainment by a paper in praise of the managers. The occasion was much enjoyed.

— The late Dr. E. H. Clarke has left his valuable library to the Boston Medical Library Association, which is fast outgrowing its present quarters.

— We see that a bill has been presented to Congress to restore Dr. William A. Hammond to the army, from which he was removed by court martial, placing him on the retired list. We are glad to learn this, and hope that the great wrong which we believe was done Dr. Hammond may be righted. There was, if we remember correctly, evidence that Dr. Hammond had not been sufficiently alive in watching those under him, but there was no question of his personal honesty. His disgrace was due to personal and political enmity.

— The fair in aid of the Carney Hospital is said to have cleared about seven thousand dollars.

MASSACHUSETTS GENERAL HOSPITAL.

CASES ILLUSTRATING THE DIAPHORETIC POWER OF JABORANDI (PILOCARPUS PINNATIFOLIUS).

SERVICE OF DR. ABBOT.

CASE I. *Chronic Bright's Disease.* — C. S., laborer, aged fifty. The patient entered the Massachusetts General Hospital, May 16th, with a history of "slow fever" many years since, and intermittent fever in 1862, while serving in the blockading fleet at the mouth of the Mississippi. On the 18th of April he had chills, general pains with headache, and his hands and feet were somewhat swollen, with occasional œdema of genitals. May 1st he had nausea and dyspnœa, and there had been nausea at times since. At the time of entering the hospital there was much ascites and anasarca, with dyspnœa, particularly at night. Oppression after food. Heart normal. Pulse 60, of good strength. Urine scanty. On examination by Professor Wood the urine was reported to be "smoky; acid; specific gravity 1012; sediment considerable, consisting of blood, a few pus cells, renal and pelvic epithelium, fibrinous and granular casts (brown, coarse, and fine), and a few fatty. Urophain normal; indican increased; chlorides and alkaline phosphates normal; sulphates and earthy phosphates diminished; urea diminishing; albumen one and a half per cent."

The patient was put upon a diet of milk only, which was continued for four days, with some increase of the flow of urine and a slight diminution of the œdema of the hands. At this time bread was added to the diet, and diuretics, with powerful cathartics, were administered until the 30th, when a decided diminution of the ascites was observed. At this date Professor Wood's report of the urine was: —

"Urine slightly smoky; acid; specific gravity 1010; considerable sediment, consisting of pus, blood, and mucus, with hyaline, granular, and fatty casts, renal epithelium, much of it fatty, bladder and some pelvic epithelium. Coloring matter, chlorides, sulphates, and alkaline phosphates normal. Urea and earthy phosphates diminished. Albumen one half of one per cent."

June 9th. The patient's face had become more puffy, and the ascites and general anasarca had increased; he had had a fair trial of the usual methods of treating these conditions, and the remedies he was then taking — digitalis, etc. — were discontinued, and two doses of infusion of jaborandi, two fluid ounces each, were directed to be given at seven and eight P. M. These caused profuse sweating, which continued an hour and a half, and was accompanied by a chilly feeling, and was followed by vomiting. The medicine was repeated on the 10th, and the sweating was attended by profuse salivation, but no nausea. The jaborandi was ordered to be continued.

June 11th. Profuse sweating and salivation until midnight. Anasarca rapidly diminishing. The medicine was discontinued until the 14th, when it was again administered with the usual effects. Its use was continued from time to time, and on the 30th the dropsy had entirely disappeared, with complete re-

lief to all the subjective symptoms. On the 8th of July the urine was found to be as previously reported, except that the specific gravity was 1013.

Case II. *Polyuria.* — May 30th. C. L., aged thirty-seven, laborer. Has been complaining ten weeks of debility, loss of appetite and flesh, having diminished in weight ten pounds. Passes a large quantity of urine and has excessive thirst. Burning at the epigastrium, with acid regurgitation. Bowels moved every second day. There is soreness with tenderness on deep pressure over the kidneys in front, but not behind. The patient ascribes his symptoms to working all day in the rain a few days before they appeared.

Urine very pale, slightly acid; specific gravity 1003. Very little sediment, containing nothing abnormal. No albumen or sugar detected.

The patient was put on a diet of bread and milk, with pudding, and tincture of muriate of iron, ten minims three times a day, was prescribed. Belladonna plaster across renal region.

June 1st. Has passed five quarts of urine.

June 2d. Six quarts. Increase each dose of iron to twenty minims.

June 3d. Patient was put on house diet, and sulphate of cinchonia, three grains, in a pill, before each meal was prescribed; the iron to be continued after meals.

June 4th. Reports that he has no sensible perspiration. No sensitiveness in region of kidneys.

"Urine pale; specific gravity 1010; a very little sediment, consisting of a few pus corpuscles and a little bladder epithelium. Indican normal. Urophain, urea, earthy and alkaline phosphates diminished. A slight trace of albumen." (Dr. Wood.)

June 5th. Has passed seven pints of urine. Feels generally better.

June 6th. Six pints of urine.

June 7th. Same.

June 8th. Seven pints.

June 9th. Seven pints. Is gaining strength. Substitute compound tincture of gentian, two fluid drachms before each meal, for the cinchonia.

On the 10th two fluid ounces of infusion of jaborandi were ordered, to be given at once and repeated in an hour.

June 11th. Perspired profusely for two hours, and vomited three or four times. Urine reduced to three pints.

June 12th. Urine six pints.

June 13th. Repeat jaborandi.

June 14th. Urine three pints. Perspiration very profuse. Appetite impaired. Omit medicine. Ordered elixir of phosphate of iron, quinine, and strychnia, one fluid drachm before each meal.

June 15th. Has had no sweating. Urine three pints.

June 16th. The same, but feels stronger. Urine four pints.

June 17th and 18th. Four pints of urine each day.

June 19th to 23d. Five pints each day. Jaborandi was again administered on the 23d.

June 24th. No sweating or nausea reported. Urine six pints. Metcalf's fluid extract of jaborandi was substituted for the infusion, in doses of ten drops every hour, until profuse sweating was produced.

June 25th. Has sweated moderately. Took five doses of fluid extract of jaborandi. Urine four pints. Repeat jaborandi.

June 26th. Had three doses of the extract, and sweat profusely for two hours; as much so as from the infusion. Continue jaborandi.

June 27th. Vomited after the third dose, and sweat moderately. Feels weak, and has less appetite.

June 27th to 30th. Passed four pints of urine each day, and on the latter date was gaining strength.

Case III. *Chronic Bright's Disease.* — Mary J. W., twenty-seven, married, entered the hospital June 16th. Has been complaining six months. Has just weaned her second child, which is two years old. Suffered much from privation and exposure during the last winter. For a year has had much temporal and occipital neuralgia, which has been nearly constant for six months. For six months has had œdema of face and eyelids; for two months anasarca, which reaches the knees; also œdema of the chest walls, and ascites. Inappetence. No appearance of catamenia for two years.

"Urine of normal acidity, 1010. Urea diminished. Albumen one and a half per cent. Considerable sediment, consisting of a few blood corpuscles, bladder and renal epithelium (some of the latter in a state of fatty degeneration), hyaline, and coarse and fine granular casts, some of them with renal epithelium adherent, and a few moderately fatty." (Mr. Hutchinson.)

Ordered ten grains of gallic acid three times a day.

June 18th. Much neuralgia of left temple. Ordered ten drops of tincture of gelsemium every three hours until relieved. Bread and milk diet.

June 19th. Neuralgia much less, but has pain at vertex, with soreness of scalp. Complains of weakness and a sense of fullness at epigastrium. Take gelsemium three times daily.

June 22d. Much less œdema below the knees, but ascites has not diminished. Ordered five minims of fluid extract jaborandi every two hours until free perspiration.

June 23d. No perspiration after three doses of jaborandi. Complains only of soreness of the left temple. Variety diet. Omit gelsemium. Increase dose of jaborandi to ten minims.

June 24th. Free from pain. Has had five doses of jaborandi, and perspired moderately from two to three hours after the fourth dose. No nausea, but thinks the medicine made her feel quite weak. Some diminution of ascites. Continue jaborandi.

The patient's condition continued to improve until the 28th, the ascites rapidly diminishing, and on that date being very slight. She vomited occasionally, and had some headache and oppression at the epigastrium, which seemed to be caused by the jaborandi, and the dose was diminished to five minims with fifteen minims of aromatic spirits of ammonia in half an ounce of water, to be given every hour until sweating was produced or weakness complained of.

June 28th. Perspired profusely three hours after seven doses of jaborandi. Had no nausea, but slight salivation. Appetite poor. The jaborandi was continued during the rest of the month, by which time the dropsy had entirely disappeared. On the 6th of July the general character of the urine was

the same as previously reported, except that the specific gravity had risen to 1022.

Case IV. *Chronic Bright's Disease; Hydrothorax.* — J. M. J., aged seventeen, teamster, entered the hospital June 25th, having been complaining nine months of œdema of face, which disappeared at times during the night. This was followed by ascites, and on April 1st by œdema of the feet. For one week he has had pain in the right groin, which shifted to the left breast near the nipple, where it now is. There has been dyspnœa on exertion for seven months, and it is increasing. For several nights past has been unable to lie down on account of dyspnœa. Examination showed extensive effusion of fluid in the left chest, œdema of legs extending half-way to the knees, and moderate ascites. Respirations 40; pulse 120. On the 26th infusion of jaborandi, one ounce, was prescribed, to be taken every hour until profuse sweating was produced, half a drachm of aromatic spirits of ammonia to be added to each dose in case of nausea.

June 27th. Feels better. Night somewhat wakeful, but had slept much the previous afternoon. Took four doses of jaborandi, and sweat freely three hours. Œdema still marked. Respirations 30; pulse 114.

Urine high colored; acid; specific gravity 1014. Urea diminished; very little sediment, containing no morbid elements. Albumen one fourth to one half per cent.

June 28th. Slept well. Face less puffed. Respirations 28; pulse 111. Repeat jaborandi.

June 29th. Sweat profusely three hours and a half after three doses of jaborandi. Has had no dyspnœa, and slept most of the night. Feels "nicely." Tongue moist and nearly clean. Œdema much less. Continue diaphoretic.

June 30th. As well. Respirations 21; pulse 96. Slept all night. Perspired freely after two doses. Thoracic effusion continues.

These cases fairly illustrate the remarkable diaphoretic properties of jaborandi (pilocarpus pinnatifolius), and show it to be a valuable addition to the juvantia in cases of dropsy.

In the first case the patient had got but moderate benefit under the ordinary treatment of such cases, but experienced most prompt and complete relief from the jaborandi. In the second the flow of urine was reduced at once in twenty-four hours from seven to three pints, and was completely under its control afterwards. In the third the dropsy was entirely removed by it. In the fourth its action was very prompt and satisfactory, the nocturnal dyspnœa being relieved from the moment it was first taken.

The copious salivation, described as one of the effects of this drug, occurred only occasionally, but in one or two instances was excessive, amounting to several pints, and so far as it went aiding in the diminution of the fluids of the system. Nausea, which was rather a common symptom after taking it, was completely prevented by the addition of a small quantity of aromatic spirits of ammonia to each dose.

THE TREATMENT OF INSANITY.

MESSRS. EDITORS, — It seems to me natural that any one who is familiar with the worst treatment of insanity thirty years ago should look upon the best treatment of that time with different eyes from one who, like myself, has become familiar with insane asylums since both the worst and the best treatment for the worst cases of that day have, happily for the patients in my opinion, become a thing of the past. The stone floors, although with cemented brick walls, the small, grated opening in the wall [1] to admit air and light, the heavy door, the darkness, the resonance of every sound, and the absence of direct communication with the external atmosphere in the places where a certain class of the insane were treated in our best asylums thirty years ago suggested to me the term "cells" for them. The expression "cellar" was used because in going to the "cells" from the main building the passage was under-ground, as is the "cellar" on its sides toward the main building and the driveway; its rear side, however, although having glass windows and being wholly above the level of the ground as it now stands on that side, was several feet removed from the front wall of the "cells," giving to one inside of them the impression of being in a cellar. It seems to me that from my stand-point I used the correct terms; and I cannot now remember any individual to whom I have ever showed the places who did not call them cells in a cellar. While I was one of the medical officers of the asylum, those were the expressions which I always used in speaking of the places, and I cannot recollect that their correctness was ever called in question. My manuscript, too, was read by three persons who had seen these "cells in the cellar," of whom one was very familiar with them, and no incorrectness was thought of. The inference that I meant that there was little to choose between these and the much worse cells at Worcester, it seems to me, could not be made by any fairly intelligent reader. Certainly it was not so meant.

I am aware, however, that others call the "cells" strong rooms, as Dr. Bell used to do, and the "cellar" a "lodge" or a basement; and several weeks ago I suggested to the writer of the article on this subject in your last week's issue the publication of an explanatory note from him to that effect, in the next Report of the State Board of Health. My point is this: By whatever name these places are called, they constituted a chief part of the treatment of the most violent insane in the very best asylums thirty years ago; and now, so far as I have been able to learn, *not one is in use for that purpose in any respectable asylum for the insane, either in the United States or in Western Europe.* I looked upon them as being on a par with the bars torn out [2] by Dr. Bell, and,

[1] Two feet high and a foot and a half wide.

[2] During the reconstruction of the north wing, begun in 1848, of which Dr. Bell said: "So far as the great ends of distinct separation and fitting classification were concerned, the buildings as left by him met this end, although *at an immense cost as regards cheerfulness of aspect, light, ventilation, facility of inspection, and readiness of service*" (page 21); and again (page 22): "While there was an adequate amount of cubic space to each inmate, — indeed, an exceedingly liberal one, as measured by other and newer institutions, — it was so distributed into dark and narrow passages, thick partition-walls, and angular lobbies that a *more dark, gloomy, repulsive interior can hardly be imagined.*" This is a year after the time referred to by me in my paper.

like the low diet, purgings, bleedings, etc., of old times, as indicating an entirely different conception of insanity and its treatment from that which I am glad to say prevails now. My use of the word "stone" for stone and brick is an error.

The McLean Asylum was the first in New England but the fifth in the United States, and when it was built the best views of that day had been introduced into this country through Dr. Rush in Philadelphia and Dr. Jones in New York. No one could for a moment suppose that I meant any imputation on the McLean Asylum nor on its first superintendent. I gave them both, and the trustees, the highest praise in my report, but I do not think that either was perfect; and if any one has misinterpreted my meaning, no one can regret the fact more than myself. I will not trouble your readers with an account of the improvements that have been made at the asylum in question, or elsewhere, in the last forty years; for they may be readily seen by consulting the official reports of that institution, especially those of Dr. Lee and Mr. Tyler (1835 and 1836), and of Dr. Bell. The McLean Asylum I have always considered, and still consider, as being in very many essential matters one of the best which I have ever seen. The names of its superintendents alone vouch for its high character; and the great improvements which have been made there, even in the last few years, should entitle the present as well as its past management to the gratitude of every lover of intelligent progress.

It seems to me that the advance to which I referred is a great one, *especially in its moral effect on the patient;* and what my critic (quoting Dr. Bell) calls the "minor advantageous changes in details" seem to me of importance, as they did to Dr. Bell. But I think I may safely refer to the trustees and superintendent of the McLean Asylum at the time the cells were abandoned, as being jealous enough of the interests in their hands not to misrepresent them, at least on the side of too great severity of criticism. In their report for 1863 (some time after such places had been abandoned for the treatment of the insane in all the other asylums of this State) the trustees say that at the time of erection the portion of the asylum of which I have been speaking was "so great an improvement over structures previously in use for the same purpose that it was looked upon as a model in its way; but for a long time its many deficiencies have been but too apparent. *This has been a theme of much discussion and deliberation;* but with the large debt hanging over the corporation the trustees did not feel warranted in adding to it, *even for an object so immediately desirable.*" (Page 12.) Again (1865), the trustees call special attention to the "very interesting and suggestive remarks" of the superintendent upon "the excellent effect of the admirable arrangements" of the new ward for the treatment of the most excited cases. I quote from these remarks as follows: "Many of the most repulsive features of extreme disorder, which are a grief to witness, and how much more to bear and to be subsequently conscious of having borne, *have become entirely unknown here,*[1] evidently by this 'step in the right direction.'" (Page 26.)

Very respectfully yours, CHARLES F. FOLSOM.

[1] The italics in this article are mine. — C. F. F.

LETTER FROM WASHINGTON.

MESSRS. EDITORS, — The accumulation of events in medical circles here has reached a point at which sufficient material may be found to furnish a letter of, it is hoped, some interest. The profession in the District of Columbia during the past year have had occasion to mourn the loss of two of their most valued members, Drs. William P. Johnston and William Beverly Drinkard. The first, after a life of usefulness and untiring energy, has gone down to the grave full of years, but still a young man in his feelings, sympathies, and energies, — little known, perhaps, outside of Washington, but here one of the most prominent and extensive of practitioners, thoroughly educated at home and abroad, long a professor of obstetrics in one of our colleges, and actively engaged in promoting the interests of our various charitable institutions. Although possessed of ample means, he gave up his active work only when the hand of death was on him, and leaves behind him, besides the record of his medical skill, the memory of a charm of manner that but few attain.

Beverly Drinkard, on the other hand, was a young man, just disclosing the extent of his rare and estimable qualities. His life was so clouded in his earlier experience by "the slings and arrows of outrageous fortune" as to throw a veil over much of it that his most intimate friends forebore to refer to. He spent the years consumed by his country in the war of the rebellion abroad, being a Southerner by birth and sympathy, cut off from his friends and all pecuniary aid, too sensitive to ask for assistance, but pursuing with a steady purpose medical instruction in the schools of Paris. At the close of the war he returned to this country, a young man of twenty-three, who had grown prematurely old, not *blasé*, not soured, but sobered, thoughtful, and earnest, with a refinement of manner that savored of affectation, but was kindly nature itself, as shown in his last words of "*au revoir*." His practice — he was attempting to make a specialty of the diseases of the eye, as far as his limited means would permit of a specialty — was large and rapidly increasing, his ability and skill as a practitioner was acknowledged by all, but the influence of his personal presence, the animal magnetism of the man, was remarkable. After his death it was fully a week before any of the students in the college in which he was professor of anatomy could compose themselves sufficiently to enter with spirit into their studies. The published remarks made in the Medical Society of the District of Columbia on the announcement of his death show a singular freedom from studied effort and stereotyped phrases, and a subdued and poignant regret. The society was wise in publishing the remarks in full, not alone as a fitting token of remembrance, but because the story of his life and death is in itself a study of value to others.

The colleges are at work as usual, with small classes of good material; both faculties seem to be in earnest in fulfilling the letter of the law as to the full term of three years' study under a suitable preceptor, and anxious to establish a high standard of requirements at the final examination, and the recommendation, for it is not yet a rule, for graded examinations seems in some in-

stances to meet with more favor from the students than from their professors. The National Medical College is timidly experimenting with a preliminary examination of candidates for its scholarships before entering upon their medical studies, Mr. W. W. Corcoran having by his generosity enabled this college to offer six endowed scholarships, the candidates for which are referred to the mother institution, the Columbian University, to report on their general fitness. In this college the place of the lamented Dr. Drinkard as professor of anatomy is filled by Dr. Elliott Coues, of the United States army, so well known as a scientist, who will probably find this a permanent station, or at least will be here for some years to come. His position in the army, according to the rules of the service, precludes his being in name a professor, but he fills the chair as a lecturer. He has this year at least, while the memory of Dr. Drinkard is still fresh, to undergo severe criticism and comparison on the part of the class, but his thorough knowledge of his subject, his enthusiastic manner, and his great acquirements in comparative anatomy and its application to evolution lend a charm to the details of his subject which relieves its dryness and impresses important facts in a new way on the student. This college has also had the advantage during the summer session of a course of lectures from Dr. Frank Loring, who signaled in this way his entrance into the specialty of diseases of the eye, so successfully followed by his brother, Dr. Edward Loring, and his lectures were appreciated and highly spoken of by his class as indicative of success in teaching.

At the same time with the opening of the colleges the clinics at the hospitals begin, as a matter of course. Providence Hospital, at present our only general hospital for clinical instruction, is virtually closed to students in the interval between March 1st and October 1st of each year. Students are told, indeed, that they are welcome during this period, but find it in fact to be otherwise. Objections and obstacles are thrown in their way, which show them very soon that they are not wanted and must confine their clinical studies to the field days for show cases, capital operations, etc., which are comparatively of but little importance to them. These obstacles seem to come from the managers of the hospital, who have almost exclusive control, and are probably as much deplored by the medical staff as by the students. The District commissioners have built recently, under the superintendence of Dr. Page, a commodious and excellent hospital for the sick of the department of charities and correction, or what stands as such, with a resident physician and a good salary. The two colleges combined their forces by selecting unofficially certain men from their faculties, and offered for the sake of clinical instruction to give proper attention to the objects of the hospital, and do away with the salaried office. Dr. Page having resigned, a suitable vacancy occurred. The salary was too great a temptation, and a large number of applications for the place were sent in, setting forth each candidate's peculiar fitness, and of course the impropriety of allowing the colleges to be interested in the hospital management was freely discussed. The consequence was the introduction of a stranger to the profession of Washington, imported under the plea that not being engaged in practice here he could devote his whole time to the interests of the institution. Now the disappointed candidates think it a shame that the colleges could not have had what they applied for.

The Columbia Lying-in Hospital is no longer open to clinical instruction, and a very material change has been made in its medical control. The former surgeon-in-chief, Dr. J. H. Thompson, was of acknowledged skill in operative surgery, and of good executive ability; he founded the hospital, as it were, and fostered its growth for years, was a more than agreeable lecturer, having a forcible manner and ready command of language, and yet the opinion of the public and profession in opposition to him became so strong in time as to compel him to offer his resignation, which was immediately accepted, the office of surgeon-in-chief abolished, and Dr. P. J. Murphy, for some years his assistant, was appointed resident physician or surgeon in charge. The fact that so young a man as Dr. Murphy could so readily obtain this position by his abilities as shown while an assistant argues well for the future prosperity of the institution, and encourages the friends of the objects for which the hospital was founded to anticipate for it in this new departure an era of prosperity. With the appointment of Dr. Murphy a new visiting staff was appointed, — the old staff having resigned, with one exception, in a body; they were representative men, standing high in the profession, but were unable under the management at that time to fill their offices with proper usefulness and self-respect. But, as it was, two of the positions were readily and easily filled, the new incumbents being looked upon up to that time as colleagues of similar standing and principles with those who were forced to vacate their offices. They, with the remaining incumbent, constituted the visiting staff for a time, but have now been added to by a very judicious selection. Dr. James T. Young, as one, obtains by this only a just recognition of his years of service in the old dispensary of the hospital, and Dr. Yarrow, of the army, brings a new and valuable element into the staff.

Society work is going on as usual, the meetings being regular, with full attendance. The Medical Association, a body which is supposed to control the ethics of the profession, has had its hands full for some time past in what it calls an investigation, and in which a good deal of feeling has been displayed. The medical departments of the United States navy and army have always been represented here by certain officers controlling the respective bureaus, and officers detailed to attend the sick among such officers and men as might require their services, and both have their special dispensaries upon which to draw for the requisite medical supplies. These officers also engage at will in private practice. The naval medical officers are frequently changed; with the army, its grand organization of hospitals, etc., during the war has since then been year by year lessened, until now no hospitals remain, and but four or five medical officers are detailed for the relief of such of the army sick as require them. During the war, while Washington was one vast camp, medical attendance and supplies were freely given to all who desired them, by army surgeons, with characteristic generosity, thus establishing a system much to the detriment of the civil practitioner in depriving him of a large class of patients that might have been profitable to him, but which was little thought of at the time, as all those in sympathy with their government could enjoy the same privileges by becoming contract surgeons. But now, in view of the complaints of a number of practitioners for several years past, that with the return of

peace this system was still used to the injury of their practice, the association, with distinct charges to this effect before it from one of its members, resolved through its committee to investigate the matter thoroughly, but unfortunately their first efforts in this direction were so ill advised as to create a strong feeling of sympathy for the person against whom they were particularly directed, Dr. J. H. Baxter, medical purveyor United States army, and to prejudice many against the whole proceeding. The member preferring charges was made to stand in the light of a prosecutor, and a circular letter was issued to almost every member of the profession in the District of Columbia asking for any evidence, personal or hearsay, which might be brought to bear upon a possible violation of the code of ethics by the party named, without at the same time making any specified charges. The result might have been anticipated. Dr. Baxter was almost unanimously and honorably acquitted without many of the members knowing what he was charged with, and with a decided expression of indignation against such an objectionable procedure. The report which was thus acted upon had a second clause which reflected in general terms upon the United States medical officers stationed here as violating the code of ethics; this was referred back to the committee for a more specific statement. In consequence a printed circular was issued by them, requiring every member to answer certain questions involving a knowledge of professional services rendered by medical officers of the army or navy free of charge to persons not so entitled to them by law, or the dispensing of medical supplies by the same under similar circumstances. To these questions the members, whatever may have been their opinions as to their propriety, were of course in honor bound to give satisfactory answers. When the answers were all in and summed up, it was found that but two contained any testimony bearing upon the subject, and neither of these came from the much-aggrieved parties who had been so long agitating the subject; they were comparatively insignificant in their character, and evidently testified to from a simple sense of duty, involving but a single medical officer, an army officer of high standing and recognized as a gentleman of warm sympathies and generous impulses, who was honorably acquitted of any intentional violation of the code of ethics. This gentleman, however, attempted a defense which was received with some surprise, and rendered in consequence the feelings of sympathy with him by no means as unanimous as they would otherwise have been, by first very properly acknowledging the truth of the testimony against him, but explaining his actions upon the plea of charity to persons in indigent circumstances, and claiming for the Army Medical Dispensary the rights and privileges of a charitable institution, when, in truth, a majority of the cases cited could not be classed in any proper sense as objects of charity. It would seem as if a much better plea could have been set up by acknowledging a want of familiarity with the petty details of the medical etiquette of civil practitioners, which to an officer brought up in either service of the United States, from the very nature of his duties, must seem irksome and unnecessary in many particulars. Some such avowal would have carried much force with it. As it is there is a feeling of disappointment, as if perfect satisfaction had not been rendered, and as if much sympathy had been wasted upon those who either had no proper causes

for complaint, or, when given the opportunity, had not the moral courage to bring them forward. Be this as it may, these gentlemen have all passed through a trying ordeal, which, after all that has been said and done, in its result reflects great credit and honor upon them. These details have been given somewhat *in extenso*, because they have formed the topic of conversation for months past in professional circles.

W. L.

November, 1877.

COMPARATIVE MORTALITY-RATES FOR THE WEEK ENDING DECEMBER 8, 1877.

	Estimated Population, July 1, 1877.	Total Mortality for the Week.	Annual Death-Rate per 1000 for the Week.	Death-Rate for the Year 1876.
New York	1,077,228	418	20.18	27.46
Philadelphia	850,856	296	18.09	22.88
Brooklyn	527,830	190	18.72	24.31
Chicago	420,000	105	13.00	20.41
Boston	363,940	105	15.00	23.39
Providence	103,000	44	22.21	18.34
Worcester	52,977	14	13.74	22.00
Lowell	53,678	19	18.41	22.21
Cambridge	51,572	19	19.16	20.54
Fall River	50,372	18	18.58	22.04
Lawrence	37,626	14	19.35	23.32
Lynn	34,524	14	21.08	21.37
Springfield	32,976	2	3.15	19.69
Salem	26,739	8	15.56	23.57

ERRATA. — In Dr. Wyman's article on The Early History of the McLean Asylum (JOURNAL, December 13th, page 680), the paragraph following Dr. Ray's letter should read as follows: "Having corrected the errors of statement as to the rooms for the violent insane, I will now consider the state of knowledge with regard to insanity generally and its treatment at the McLean."

BOOKS AND PAMPHLETS RECEIVED. — Katatonica, a Clinical Form of Insanity. By J. G. Kiernan, M. D. (From the American Journal of Insanity.)

Cause of Death at Wallach School Building. A Report by S. A. H. McKim, M. D. Washington. 1877.

Modern Medical Therapeutics. A Compendium of Recent Formulæ and Specific Therapeutical Directions. By George H. Napheys, A. M., M. D., etc. Fifth Edition. Enlarged and revised. Philadelphia: D. G. Brinton. 1878.

Diseases of the Nervous System. By Julius Althaus, M. D. New York: G. P. Putnam's Sons. 1878.

The Action of Medicines. By Isaac Ott, A. M., M. D. Philadelphia: Lindsay and Blakiston. 1878. (From A. Williams & Co.)

Diseases of the Nasal Cavity and the Vault of the Pharynx. Translated from the German of Dr. Carl Michel, of Cologne-on-the-Rhine. With an Introduction by E. S. Thurley, M. D., and C. C. Yemans, M. D. Detroit. 1877.

The Drunkard's Diseased Appetite. What is it? etc.

The Dogma of Human Responsibility, more especially as it relates to Inebriety. By Rev. J. Willett.

Excision of the Knee-Joint. By George E. Fenwick, M. D. (From the Transactions of the Canada Medical Association.) 1877.